THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED DEC 30 1957

45566 STATE FILE NUMBER 12025

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St.Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hamilton Med.Center — Length of stay in 1b 5 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St.Louis
c. CITY OR TOWN University Citym 4326 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 1029 Irma — Reside on Farm Yes [ ] No [X]

37 27

3. NAME OF DECEASED (Type or print) First DORA Middle Last ARNOSKE

4. DATE OF DEATH Month Day Year Dec.14,1957

5. SEX Female
6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH unk.
9. AGE (In years last birthday) ab.92 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Russia
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Unk
13b. MOTHER'S MAIDEN NAME Unk.
14. NAME OF HUSBAND OR WIFE Abraham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Address Nathan Ferman 1471 Coolidge

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH 40 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebro arterio sclerosis — years
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 331x
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Oct, 15, 1956 to Dec 14, 1957 and last saw her him alive on Dec 14, 1957
Death occurred at 9:30 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Aaron Henkin MD
22b. ADDRESS 607 No Grand
22c. DATE SIGNED 12/14/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.
23b. DATE 12/15/57
23c. NAME OF CEMETERY OR CREMATORY Beth Hamedrosh Hagodol
23d. LOCATION (City, town, or county) (State) Ladue, Mo.

24. FUNERAL DIRECTOR ADDRESS Berger Memorial 4715 McPherson
25. DATE RECD. BY LOCAL REG. DEC 16 57
26. REGISTRAR'S SIGNATURE Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. ..... working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Louis J. Dorn

Licensed Embalmer No. 3988

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.